2 PEACHTREE ST., NW, 36TH FLOOR – ATLANTA, GA, 30303 – PH 404.656.3913 – FAX 404.656.9723

GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

APPLICATION FOR

VOLUNTEER IN MEDICINE LICENSE

PLEASE READ ALL INSTRUCTIONS

APPLICATION FOR VOLUNTEERS IN MEDICINE LICENSE IN GEORGIA
GEORGIA COMPOSITE STATE BOARD OF MEDICAL EXAMINERS
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GENERAL INFORMATION

The Volunteers in Medicine Act provides for the issuance of a special license at no fee, nor are there any renewal fees needed. The Board may issue at its discretion and without examination, a special medical license to qualifying physicians for the sole purpose of practicing medicine in Georgia. To apply for a Volunteer in Medicine (VIM) license, you must meet the following requirements:

1. Possess a current license to practice medicine in good standing in any medical-licensing jurisdiction in the United States or
2. Have retired from the full or part-time practice of medicine and, prior to retirement, maintained a license to practice medicine in good standing in any medical-licensing jurisdiction in the United States.

O.C.G.A. § 51-1-19.1 shall govern the liability of physicians practicing under this code section and their employers.

Any physician possessing this license shall not be authorized to perform surgery or any surgical procedure.

Any person who practices medicine without complying with this article or violates any provision of this article shall be guilty of a felony and upon conviction, shall be punished by a fine of not less than $500 nor more than $1,000, or by imprisonment from two to five years or both.

Filling false credentials or giving forged evidence of any kind in connection with this application shall be guilty of a felony and upon conviction shall be punished by a fine of not less than $500.00 nor more than $1,000 or by imprisonment for two to five years.

Anytime you change volunteer agencies, you must notify the medical board and have your new employer fill out the notarized statement from a volunteer agency. You may not practice until the Board approves the change in employment.

You must provide documentation indicating that you have no disciplinary action taken against your license by any state, and have not let your license in any state expire or become inactive during an investigation by a state medical board into allegations relating to your practice of medicine or during a pending disciplinary action.

You must provide all documentation requested and this documentation must be complete, including all required forms, seals and signatures.

Volunteers In Medicine licenses are valid for two years, expiring on December 31st of the odd year.

TEMPORARY VOLUNTEERS IN MEDICINE LICENSES:

A nonrenewable temporary license to practice for a period of six months will be issued to applicants not in compliance with the Board's CME requirements but otherwise qualified to obtain a VIM license.

CONTACT INFORMATION

If your last name begins with:	then please call:
A, B, C, D, E	404-463-6162
F, G, H, I, J, K	404-657-6491
L, M, N, O, P, Q	404-651-7853
R, S, T, U, V, W, X, Y, Z	404-656-7067

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CHECKLIST

FAILURE TO PROVIDE ANY REQUIRED OR REQUESTED DOCUMENTATION MAY RESULT IN A DELAY IN THE PROCESSING OF YOUR APPLICATION.

1. DOCUMENTATION PROVIDED BY APPLICANT: Checklist

- ❑ Notarized copy of your medical degree
- ❑ Résumé or CV
- ❑ Copies of documentation of 40 hours of CME over the last two years as follows:
  - AMA, CATEGORY 1
  - A0A, CATEGORY 1
  - AAFP, PRESCRIBED CREDIT
  - ACOG, COGNATES, CATEGORY 1
  - ACEP, CATEGORY 1

2. REQUIRED FORMS: Checklist

- ❑ APPLICATION PAGES 1-4 – Complete all required signatures, dates, and if you answer "yes" to any question, provide a detailed explanation of the circumstances surrounding the event.

- ❑ AFFIDAVIT – This form must be completed and then notarized by a Notary Public on the date you sign it. Include an original photograph, preferably a passport photo.

- ❑ STATE VERIFICATION FORM – Send this form to all states where you have held a license to practice medicine. This form must be sent directly to the Board from the verifying authority.

- ❑ VERIFICATION OF EMPLOYMENT – This form must be completed by the applicant's employer documenting the applicant's agreement not to receive compensation for any medical services rendered while practicing with a VIM license. This form must be completed by the agency, institution or facility where you will be doing the volunteer work and must be notarized. This form must be sent directly to the Board from the verifying authority.

NOTE: WE WILL DISCUSS APPLICATION STATUS WITH THE APPLICANT <u>ONLY</u>.
Applications are confidential pursuant to State law. Therefore, application status updates must be obtained from the applicant. Please inform all hospitals, employers, recruiters, referral companies, family members, or insurance companies that application status updates must be obtained from you.

BRIEF OVERVIEW

Please read all application materials and instructions carefully. It takes approximately eight to twelve weeks to obtain a Volunteer in Medicine (VIM) license in Georgia.

It is recommended that applicants wait until 15 days, or until receipt of a deficiency letter, to contact the staff by phone regarding the status. This time frame allows for outside source documents to be received and matched to the file. It is imperative for applicants to understand that the review process is guided by the requirements set forth in State law, <u>which does not provide for any waivers to be granted by staff.</u>

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GEORGIA MEDICAL BOARD (GMB) USE ONLY

APPL. NUMBER	_____	FILE NUMBER	_____
RECEIVED	_____	COMPLETED	_____
TEMP LIC NO	_____	EXPIRATION DATE	_____
LICENSE NO	_____	DATE ISSUED	_____
WITHDRAWN	_____	DENIED	_____

REQUIRED DOCUMENATION:
GA MEDICAL BOARD USE ONLY
CURRENT LICENSE IN GOOD STANDING
RETIRED LICENSE IN GOOD STANDING
COPY OF MEDICAL DEGREE
STATE VERIFICATION
NOTARIZED EMPLOYMENT FORM
40 HOURS CME
NPDB
HIPDB
RESUME
AFFIDAVIT

BASIC INFORMATION

GMB

INSTRUCTIONS: Provide your full legal name, in the format indicated on the application. This is the name that will be printed on the license and reported to hospitals and those who inquire about licensure.

LAST NAME	FIRST NAME	MIDDLE NAME	❑
MAIDEN NAME		DEGREE (MD OR DO)	❑
Other names under which material may be submitted – Do not use nicknames			❑
US Social Security Number:			❑

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. § 651 and 20 U.S.C.A. § 1001. This information also **may** be disclosed to the National Practitioner's Data Bank (NPDB) or other state medical boards or regulatory agencies for license tracking purposes. ❑

❑ **I do not wish this information to be released to the NPDB or other medical boards or other regulatory agencies for license tracking purposes.**

INSTRUCTIONS: Provide your mailing address. Georgia law requires that you keep the Board informed of any address changes to include street address, city, state, zip code, and phone number. If you have an address change during the application process, you may fax this change to 404-656-9723. This should include the old address and the change. The importance of your address is evident during the renewal process as licenses expire on December 31 of the odd year. This would be an address you do not mind having posted on the internet. If you prefer your business address as the mailing address, indicate this by checking the appropriate box. The Board does require a street address for its records if you use a PO Box as your mailing address.

RESIDENCE STREET ADDRESS			APARTMENT #	❑
CITY	STATE	ZIP CODE	COUNTY	❑
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)		E-MAIL ADDRESS (OPTIONAL)	❑
			☐ **Mailing address**	❑
BUSINESS STREET ADDRESS			SUITE #	❑
CITY	STATE	ZIP CODE	COUNTY	❑
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)		E-MAIL ADDRESS (OPTIONAL)	❑
			☐ **Mailing address**	❑

BASIC INFORMATION - CONTINUED					GMB
DATE OF BIRTH (MM/DD/YY)	PLACE OF BIRTH:	CITY	STATE	COUNTY	❑
HOW LONG HAVE YOU LIVED IN THE US? _____YEARS _____MONTHS					❑
HAVE YOU SERVED IN THE ARMED FORCES? ❑ YES ❑ NO HAVE YOU BEEN DISCHARGED? ❑ YES ❑ NO	DATES OF SERVICE (MM/DD/YY – MM/DD/YY) _____ DATE OF DISCHARGE _____ TYPE _____				❑ ❑

TRAINING

INSTRUCTIONS: For pre-medical education (college) and medical/osteopathic education, indicate all beginning and ending months and years of each of attendance. Any gaps in training must be explained. Do not group years together, i.e., 1997 – 2001. Each year of attendance must be accounted for, or this section will be returned. Attach additional sheets if necessary.

PRE-MEDICAL EDUCATION		❑
NAME OF COLLEGE ATTENDED	**DATES OF ATTENDANCE – MONTH AND YEAR (MM/YY TO MM/YY)**	
	1ST YEAR	
	2ND YEAR	
	3RD YEAR	
	4TH YEAR	

MEDICAL/OSTEPATHIC EDUCATION		❑
NAME OF MEDICAL SCHOOL ATTENDED	**DATES OF ATTENDANCE – MONTH AND YEAR (MM/YY TO MM/YY)**	
	1ST YEAR	
	2ND YEAR	
	3RD YEAR	
	4TH YEAR	

If you attended more than four years of medical school, continue below:		❑
	5th YEAR	
	6th YEAR	

LICENSE VERIFICATION

INSTRUCTIONS: Original verifications of license history certification is required for each permanent, temporary, training, provisional, or limited license obtained in any state in the US or Canadian territory, Canadian province, or US Federal jurisdiction. The issuing authority should mail the verification to the Medical Board. If licensed by examination, give the state. If licensed by reciprocity, provide the state. Provide the current status of the license: active, inactive, revoked, suspended, probation, limited, etc.

	GMB
STATE/COUNTRY	❑
DATES OF LICENSURE (MM/DD/YY – MM/DD/YY)	❑
LICENSED BY:	❑
CURRENT STATUS OF LICENSE:	❑
STATE/COUNTRY	❑
DATES OF LICENSURE (MM/DD/YY – MM/DD/YY)	❑
LICENSED BY:	❑
CURRENT STATUS OF LICENSE:	❑
STATE/COUNTRY	❑
DATES OF LICENSURE (MM/DD/YY – MM/DD/YY)	❑
LICENSED BY:	❑
CURRENT STATUS OF LICENSE:	❑
Copy this page if you have more licenses than this space allows.	❑

APPLICANT QUESTIONNAIRE

If you answer "YES" to questions 1-19, you are required to furnish complete details, including date, place, reason and disposition of the matter. Failure to furnish the documentation may result in a delay in the application process.

		YES	NO	GMB
1.	Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years? (If you answer yes to this question, provide letter(s) from all treating physician(s) directly to Board.)	❑	❑	❑
2.	Have you ever been arrested for and/or convicted of a violation of any National, Federal (including military), State or Local State statute?	❑	❑	❑
3.	Have you ever been denied the privilege of taking an examination given by any licensing Board or agency?	❑	❑	❑
4.	Has any licensing Board or agency ever denied you a certificate or a license?	❑	❑	❑
5.	Has any licensing Board or agency ever refused you renewal of a certificate or a license?	❑	❑	❑
6.	Have you ever been denied a DEA registration number?	❑	❑	❑
7.	Have you ever been issued a restricted DEA registration?	❑	❑	❑
8.	Are you currently registered with the DEA?	❑	❑	❑
	If you are registered with the DEA, provide the number and state of issue below:			
	DEA Number _____ State of issue_____			❑
9.	Have you ever been denied membership in or in any way sanctioned by any medical or osteopathic association, society, or specialty society?	❑	❑	❑
10.	Have you ever resigned from a hospital staff position or training program after a complaint or peer review action has been initiated against you?	❑	❑	❑
11.	Have you ever voluntarily surrendered a medical license?	❑	❑	❑
12.	Have you ever voluntarily surrendered a controlled substance registration?	❑	❑	❑
13.	Have you ever voluntarily surrendered a DEA registration?	❑	❑	❑
14.	To your knowledge, are you the subject of an investigation by any licensing Board or agency as of the date of this application?	❑	❑	❑
15.	Do you have any applications for licensure pending before any other licensing Board or agency?	❑	❑	❑
16.	Have you ever had any restrictions as a Medicaid or Medicare provider?	❑	❑	❑
17.	Are you in default on a state or federally funded and/or guaranteed school loan?	❑	❑	❑
18.	Are you in default on child support payments?	❑	❑	❑
19.	Did you include a copy of your CV or résumé with this application packet?	❑	❑	❑

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AFFIDAVIT OF APPLICANT

TOP OF PHOTO (HEAD)

PHOTO AREA
PASTE A 2 ¼ " X 3"
PHOTO HERE.

PHOTO MUST BE OF
YOUR HEAD
AND SHOULDER AREAS ONLY

BOTTOM OF PHOTO (SHOLDERS)

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Georgia Law that authorizes collection of this information. The information on your application may be transferred to other medical licensing authorities the Federation of State Medical Boards or other governmental or law enforcement agencies.

I acknowledge and state that I have read the Application for Volunteers in Medicine Information and Applicant Instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Medical Practice Act and the Board Rules.

I further state that by filing this application for a Volunteers in Medicine license in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information, which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I request and authorize any treatment program to release alcohol and drug abuse patient records to the Composite State Board of Medical Examiners for the purpose of evaluating my fitness to practice. The consent of this paragraph is subject to revocation pursuant to federal regulations and terminates upon the date of termination of medical licensure in Georgia.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or International), court, association, institution, or other organization having control of my documents, records and other information pertaining to me, to furnish to the Georgia Composite State Board of Medical Examiners any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Composite State Board of Medical Examiners or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice there under.

I authorize and request the Georgia Composite State Board of Medical Examiners to obtain any criminal history information concerning me from any authorized law enforcement agency, including but not limited to the Georgia Crime Information Center (GCIC) and the National Crime Information Center (NCIC).

I hereby release, discharge, and exonerate the Georgia Composite State Board of Medical Examiners, its agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Composite State Board of Medical Examiners.

This is to certify that the forgoing information is true and correct to the best of my knowledge. I understand that pursuant to the Official Code of Georgia Annotated, Section 43-34-46, any person who shall give false or forged evidence of any kind to the Board in connection with an application for a license to practice medicine shall be guilty of a felony and upon conviction thereof, shall be punished by a fine of not less than $500.00 nor more than $1,000.00, or by imprisonment from two to five years, or both.

SIGNATURE OF APPLICANT	DATE	CITY	COUNTY	STATE

PRINTED NAME OF APPLICANT	Being duly sworn, says that he/she is the person who executed the above application for a Volunteer in Medicine license in the State of Georgia; that all the statements herein contained are true in every respect; and that the attached photo is a true photo of the applicant.	NOTARY SEAL MUST BE IMPRINTED HERE

Sworn and subscribed to me this _____day of _____, _____

_____(Notary Public)

My Commission Expires

_____

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INSTRUCTIONS: Original verifications of license history certification is required for each permanent, temporary, training, provisional, or limited license obtained in any state in the US or Canadian territory, Canadian province, or US Federal jurisdiction. The issuing authority should mail the verification to the Medical Board. If licensed by examination, give the state.

STATE BOARD LICENSE VERIFICATION

Section I: To be completed by applicant. This form should be sent to each state in which you are now or ever have been licensed to practice medicine. This form may be photocopied.

TO: _____ Board of Examiners

I am applying for a Volunteer in Medicine License. The Georgia Board requires that your Board complete this form in order that my application may be considered. By signing this form, I give my consent to the release of any information, favorable or otherwise, for its review, in considering me for licensure. Please mail the completed form as soon as possible to the Board at the address listed below.

My license number: _____was issued by your Board on _____ on the basis of

☐ State Board Exam ☐ FLEX ☐ National Board ☐ National Osteopathic ☐ LMCC ☐ USMLE

FULL NAME _____ STREET ADDRESS _____ APT. NO.

SIGNATURE _____ CITY _____ STATE _____ ZIP _____

Section II: This Section To Be Completed By An Official Of The Above Referenced Licensing Board. Do Not Return This Form To Physician.

ATTN: PHYSICIAN LICENSURE
Georgia Composite State Boards of Medical Examiners
2 Peachtree Street, NW 36TH FLOOR
Atlanta, Georgia 30303

Medical License Number _____to practice medicine and surgery in the

State of _____ was issued on _____ to Dr. _____

Is license current and in good standing? ☐ Yes ☐ No
Has any disciplinary action ever been taken against this physician? ☐ Yes ☐ No

PLEASE PROVDE COMPLETE DETAILS, INCLUDING COPIES OF ANY DOCUMENTS.

_____ _____
Signed Date

_____
Title

_____ BOARD SEAL MUST BE IMPRINTED HERE
State Board

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INSTRUCTIONS: This form must be completed by the applicant's employer documenting the applicant's agreement not to receive compensation for any medical services rendered while practicing with a VIM license. This form must be completed by the agency, institution or facility where you will be doing the volunteer work and must complete and notarize this form. This form must be sent directly to the Board from the verifying authority.

VOLUNTEERS IN MEDICINE - VERIFICATION OF EMPLOYMENT

I hereby attest that _____ who will be working in the employment of
PHYSICIAN'S NAME

_____ shall unequivocally not receive compensation for
FACILITY/AGENCY NAME

Any medical services he or she may render while in possession of a Volunteer in Medicine License.

I further attest that this is a public agency or institution, not for profit agency, not for profit institution; or not for profit corporation and further, we provide services only to indigent patients in medically underserved areas or critical need population areas of the State.

_____ _____
Printed name of OWNER/CEO PHYSICIAN'S SIGNATURE

_____
Printed name of Physician

_____
FACILITY/INSTITUTION/AGENCY

_____
ADDRESS CITY/STATE/ZIP

_____
(AREA CODE) TELEPHONE NUMBER

SIGNATURE OF OWNER/CEO	DATE	CITY	COUNTY	STATE

Sworn and subscribed to me this _____day of _____, _____

_____(Notary Public)

My Commission Expires

_____

NOTARY SEAL MUST BE IMPRINTED HERE